3. Declaration of Consent

For storage, transmission, and collection of patient data

(§ 73 Abs. 1 b SGB V und nach DSVGO Art. 9, Abs 2 und Art. 7)

Last name, First name: _____

Address: _____

Date of Birth: _____

Dear patient,
We would like to give you the best treatment possible. We take privacy very seriously; however, it may be necessary for us to transmit necessary personal data to other doctors or service providers who are treating you or request this patient data from them. For this we need your consent for storage of your patient data.

I. Storage, Transmission and Collection of Patient Data

By signing this form, you agree that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- It may be necessary to transfer protected health information for further treatment to other physicians by mail or fax.
- Protected health information may be requested and transferred from other physicians to Dr. Murray's office for further treatment and storage.

II. Patient Service (RECALL)

We also offer our patients an appointment notification service. If you agree, we will inform you about medical examinations or vaccinations in the future and we may contact you by email, SMS, or phone.

☐ I agree to being informed
☐ I do not consent to being informed

III. Revocation / Retraction

I was made aware of the fact that I can revoke/retract this declaration of consent, in whole or in part, in writing, at any time.

_____	_____	_____
Place	Date	Signature of Patient of Legal Representative